Fiscal Year 2010
Child and Adult Care Food Program
Affidavit for Free and Reduced-Price Meals For
Adult Day Care Participants

To assist the Adult Day Care in receiving reimbursement for meals, please provide the following information.

PART 1

Name(s) of adult(s) attending Adult Day Care.	**Signature of adult participant (or designated family member)**
1._____	1._____
2._____	2._____
3._____	3._____

PART 2

Complete this part for adult participants attending this center who are currently receiving Food Stamp, FDPIR, SSI or Medicaid Assistance. Then complete Part 4. **If not receiving these benefits, precede to Part 3.**

	Adult Participant	Food Stamp Case No.	FDPIR Case No.	ALTCS/ AHCCCS No.	SSI Social Security No.
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

PART 3

Complete this section for adult participants in Part 1 who are not receiving the benefits listed in Part 2. Do not list adult participants who are listed in Part 2.

HOUSEHOLD MEMBERS: List the names of adult participant(s), Spouse(s) and dependents residing in the household**.**

MONTHLY INCOME: Write the amount of monthly **gross** income (before any deductions) of each person on the corresponding line. For self-employed persons, record **net** earnings.

	NAME (Last, First)	Monthly Earnings from Work (**Gross** Wage Earnings; **Net** Self-employment earnings)	Monthly Welfare Payments, Child Support, TANF & Alimony	Monthly Income from Pensions, Retirement and Social Security	Monthly Income from any other source
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____

PART 4

Printed Name _____
Address _____
_____
Home Telephone Number _____
Work Telephone Number _____

CONFIDENTIALITY: The information provided on this affidavit will be treated in a confidential manner and will be used only for the purposes of eligibility determination and verification of data for the Child and Adult Care Food Program.

Notice: By signing this Affidavit, the signer hereby attests that the information provided is true and accurate. The signer understands; that this information is being given in connection with the receipt of Federal funds; that center officials may verify this information; and that deliberate misrepresentation may subject the signer to prosecution under applicable State and Federal criminal statutes.

_____	_____	_____
Signature of person completing form	Social Security Number (If none write word "NONE")	Date

To be completed by Adult Day Care Determining Official

Signature of Approval: _____
Date Approved: _____

Total Household Size: _____
Total Monthly Income: _____

Eligibility category:
( ) Free
( ) Reduced
( ) Paid

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Dear Adult Day Care Participant and Family/Caregiver,

The Child and Adult Care Food Program require that the reimbursement this Center receives for meals served to all adults be based on income information submitted by each adult. This benefits you because it helps to keep the charge for adults at a lower rate. This information will be kept confidential. If your household has income less than or equal to the income levels below, the Center receives more reimbursement for the meals served to adult participants.

Income Criterion for Reduced-Priced Meals
Effective from July 1, 2009 to June 30, 2010

Household Size	Annual Income	Monthly Income	Weekly Income
1	$20,036	1,670	386
2	26,955	2,247	519
3	33,874	2,823	652
4	40,793	3,400	785
5	47,712	3,976	918
6	54,631	4,553	1,051
7	61,550	5,130	1,184
8	68,469	5,706	1,317
Each Additional Member Add:	+6,919	+577	+134

In operation of Child and Adult feeding programs, no adult will be discriminated against because of race, color, national origin, sex, age, or disability. If you believe that you have been discriminated against in any USDA-related activity, you should write immediately to the Security of Agriculture, Washington, DC 20250.

ADULTS WITH DISABILITIES: If an adult has been determined by a doctor to be disabled and the disability would prevent the adult from eating a regular meal, this center will make any substitutions prescribed by the doctor. If a substitution is needed and documentation is presented to the center, there will be no extra charge for the meal

Adult participants attending this center who are receiving Food Stamp, FDPIR, SSI or Medicaid Assistance are eligible for free priced meals only if the adult participant's name, the appropriate case number(s), and the signature of the adult household member who completed the application is included on the affidavit.

Households with incomes less than or equal to the income chart for reduced-priced meals above are eligible for free or reduced-priced meals. In order for the center to be considered eligible for free and reduced-price meals based on income, an application must contain complete documentation of eligibility information including total current household income, names of all household members, the social security numbers of the household member who signs the application, or the word "None" and the date and signature of the adult household member who completed the application.

Household members who become unemployed make the Center eligible for free or reduced-price meals during the period of unemployment, provided that the loss of income causes the family income, during the period of unemployment, to be within eligibility standards for those meals.

Section 9 of the National School Lunch Act requires that, unless a food stamp, SSI, AHCCCS or FDPIR Case number is provided, you must include a social security number on the application. This must be the social security number of the adult household member signing the application, or an indication that the household member does not have one. Provision of a social security number is not mandatory, but if a social security number is not provided or an indication is not made that the adult household member signing the application does not have one, the application cannot be approved. This notice must be brought to the attention of the household member whose social security number is disclosed. The social security number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the application. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting food stamp or other office to determine current certification for receipt of food stamps, SSI, AHCCCS or FDPIR benefits, and/or contacting the State employment security office to determine the amount of benefits received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

RACE: Please check the race or ethnic identity of participant. You are not required to answer this question to get meal benefits, but completion of this information will help ensure that everyone is treated fairly.

WHITE	BLACK/AFRICAN AMERICAN	HISPANIC/ LATINO	AMERICAN INDIAN/ ALASKA NATIVE	NATIVE HAWAIIAN/ PACIFIC ISLANDER	ASIAN	SOME OTHER/ RACE(S)

PLEASE COMPLETE THE REVERSE SIDE